		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTOR PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 8027823

Facility Name: Thomas H Boyd Memorial Hsp

Address: 800 School Street (Number) Carrollton (City) 62016 (Zip Code)

County: Greene

Telephone Number: (217) 946-6946 **Fax #** (217) 942-9012

IDPA ID Number: 37-0673461002

Date of Initial License for Current Owners:

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501(c)(3)	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Sandra Purcell, CFO **Telephone Number:** (217) 946-6946

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to th State of Illinois, for the period from 9/1/00 to 8/31/01 and certify to the best of my knowledge and belief that the said content are true, accurate and complete statements in accordance wit applicable instructions. Declaration of preparer (other than provide is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any informatio in this cost report may be punishable by fine and/or imprisonmen

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Deborah Campbell
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	40	Skilled (SNF)	40	14,600	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	40	TOTALS	40	14,600	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0	27		27	8
9	SNF/PED					9
10	ICF	3,170	8,947		12,117	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,170	8,974		12,144	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.18%

D. How many bed-hold days during this year were paid by Public Aid?
14 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Prisoner meals

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location
Date started 01/19/1970

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 8/31/01 Fiscal Year: 8/31/01

* All facilities other than governmental must report on the accrual basi

STATE OF ILLINOIS

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary							199,530	199,530			1
2	Food Purchase											2
3	Housekeeping							97,837	97,837			3
4	Laundry							36,960	36,960			4
5	Heat and Other Utilities							74,965	74,965			5
6	Maintenance											6
7	Other (specify):*											7
8	**TOTAL General Services**							409,292	409,292			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	400,988		1,500	402,488		402,488	75,826	478,314			10
10a	Therapy											10a
11	Activities	13,778		706	14,484		14,484		14,484			11
12	Social Services	18,181		2,406	20,587		20,587		20,587			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	432,947		4,612	437,559		437,559	75,826	513,385			16
	C. General Administration											
17	Administrative		7,381		7,381	(21,870)	(14,489)	99,987	85,498			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expense			1,898	1,898		1,898		1,898			21
22	Employee Benefits & Payroll Taxe							98,318	98,318			22
23	Inservice Training & Educatior											23
24	Travel and Seminar			221	221		221		221			24
25	Other Admin. Staff Transportatior											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	**TOTAL General Administration**		7,381	2,119	9,500	(21,870)	(12,370)	198,305	185,935			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	432,947	7,381	6,731	447,059	(21,870)	425,189	683,423	1,108,612			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $100(

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassificatior

Facility Name & ID Number Thomas H Boyd Memorial Hsp #8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							14,050	14,050			30
31	Amortization of Pre-Op. & Org											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**							14,050	14,050			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	3,052		150	3,202		3,202		3,202			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					21,870	21,870		21,870			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	3,052		150	3,202	21,870	25,072		25,072			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	435,999	7,381	6,881	450,261		450,261	697,473	1,147,734			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona				25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organizatior Costs (Schedule VII)	624,105		34
35	Other- Attach Schedule	73,368	10	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 697,473		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 697,473		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Thomas H Boyd Memorial Hsp

ID# 8027823

Report Period Beginning: 9/1/00

Ending: 8/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 **Report Period Beginning:** 9/1/00 **Ending:** 8/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	199,530	0	0	0	0	0	0	0	0	0	199,530	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	97,837	0	0	0	0	0	0	0	0	0	97,837	3
4	Laundry	0	36,960	0	0	0	0	0	0	0	0	0	36,960	4
5	Heat and Other Utilities	0	74,965	0	0	0	0	0	0	0	0	0	74,965	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	409,292	0	0	0	0	0	0	0	0	0	409,292	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	73,368	2,458	0	0	0	0	0	0	0	0	0	75,826	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	73,368	2,458	0	0	0	0	0	0	0	0	0	75,826	16
	C. General Administration													
17	Administrative	0	99,987	0	0	0	0	0	0	0	0	0	99,987	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	98,318	0	0	0	0	0	0	0	0	0	98,318	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	198,305	0	0	0	0	0	0	0	0	0	198,305	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	73,368	610,055	0	0	0	0	0	0	0	0	0	683,423	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Thomas H Boyd Memorial Hsp **#** 8027823 **Report Period Beginning:** 9/1/00 **Ending:** 8/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	14,050	0	0	0	0	0	0	0	0	0	14,050	30
31	Amortization of Pre-Op. & Org	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):[4]	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	14,050	0	0	0	0	0	0	0	0	0	14,050	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportatior	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):[4]	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	73,368	624,105	0	0	0	0	0	0	0	0	0	697,473	45

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		NONE		Thomas H. Boyd Memorial Hospital	Carrollton	Hospital

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Bldg. Depreciation	$	Thomas H. Boyd Memorial Hospita	100.00%	$ 12,342	$ 12,342	1
2	V	30	Equip. Depreciation		Thomas H. Boyd Memorial Hospita	100.00%	1,708	1,708	2
3	V	22	Employee Benefits		Thomas H. Boyd Memorial Hospita	100.00%	77,455	77,455	3
4	V	17	Administrative & General		Thomas H. Boyd Memorial Hospita	100.00%	99,987	99,987	4
5	V	5	Operation of Plant		Thomas H. Boyd Memorial Hospita	100.00%	74,965	74,965	5
6	V	4	Laundry & Linen		Thomas H. Boyd Memorial Hospita	100.00%	36,960	36,960	6
7	V	3	Housekeeping		Thomas H. Boyd Memorial Hospita	100.00%	97,837	97,837	7
8	V	1	Dietary		Thomas H. Boyd Memorial Hospita	100.00%	199,530	199,530	8
9	V	22	Cafeteria		Thomas H. Boyd Memorial Hospita	100.00%	20,863	20,863	9
10	V	10	Medical Records		Thomas H. Boyd Memorial Hospita	100.00%	2,458	2,458	10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 624,105	$ * 624,105	14

* Total must agree with the amount recorded on line 34 of Schedule VI

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8				N/A							8
9		BOARD OF DIRECTORS RECEIVE NO COMPENSATION									9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic or parent organization costs? (See instructions. YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheet

Name of Related Organization: Thomas H. Boyd Memorial Hospital
Street Address: 800 School Street
City / State / Zip Code: Carrollton, IL 62016
Phone Number: (217) 942-6946
Fax Number: (217) 942-9012

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Bldg. Depreciation	Square Feet	44,209		$ 44,463	$	12,273	$ 12,344	1
2	30	Equip. Depreciation	Dollar Value	55,239		59,742		1,579	1,708	2
3	22	Employee Benefits	Gross Salaries	2,923,466		519,349		435,999	77,455	3
4	17	Administrative & General	Accumulated Cost	4,263,748		786,933		541,766	99,990	4
5	5	Operation of Plant	Square Feet	43,927		268,311		12,273	74,965	5
6	4	Laundry & Linen	Pounds of Laundry	88,272		52,279		62,406	36,960	6
7	3	Housekeeping	Hours of Service	2,061		197,494		1,021	97,837	7
8	1	Dietary	Meals Served	40,310		222,337		36,175	199,530	8
9	22	Cafeteria	Meals Served	26,120		67,378		8,088	20,863	9
10	10	Medical Records	Time Spent	939		135,753		17	2,458	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,354,039	$		$ 624,110	25

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1				NOTE: THE PROVIDER CANNOT IDENTIFY THE			$	$			$	1
2				NURSING HOME SHARE OF ANY INTEREST								2
3				COST BECAUSE IT IS ALLOCATED THROUGHOUT								3
4				THE HOSPITAL VIA THE MEDICARE COST REPORT.								4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	N/A	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	N/A	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	N/A	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	N/A	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	N/A	8
1997	N/A	9
1998	N/A	10
1999	N/A	11
2000	N/A	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual o taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of ar application for real estate tax exemption unless the building is rented from a for-profit entity This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Thomas H Boyd Memorial Hsp COUNTY Greene

FACILITY IDPH LICENSE NUMBER 8027823

CONTACT PERSON REGARDING THIS REPORT Sandra Purcell, CFO

TELEPHONE (217) 946-6946 FAX #: (217) 942-9012

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$ N/A	$ N/A
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____YES _____NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc. List entity name, type of business, square footage, and number of beds/units available (where applicable)

THOMAS H. BOYD MEMORIAL HOSPITAL OWNS THE FACILITY AND GROUNDS. THE NURSING HOME OCCUPIES 12,273 OF THE 44,208 TOTAL SQUARE FEET.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	PATIENT CARE			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	40		1970	1970	$ 328,500	$ 3,413	20-40	$ 3,413	$	$ 299,493	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 328,500	$ 3,413		$ 3,413	$	$ 299,493	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 106,999	$ 4,129	$ 4,129	$		$ 89,817	71
72	Current Year Purchases	28,960	1,448	1,448			1,448	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 135,959	$ 5,577	$ 5,577	$		$ 91,265	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 464,459	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 8,990	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 8,990	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 390,758	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 **Report Period Beginning:** 9/1/00 **Ending:** 8/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 8/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 158,498	$ 158,498	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable Patients (less allowance 355,000)	1,156,299	1,156,299	3
4	Supply Inventory (priced a cost)	23,089	23,089	4
5	Short-Term Investments			5
6	Prepaid Insurance	64,376	64,376	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties			8
9	Other(specify)			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,402,262	$ 1,402,262	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	430,860	430,860	13
14	Buildings, at Historical Cos	1,881,289	1,881,289	14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cos	1,161,266	1,161,266	16
17	Accumulated Depreciation (book methods	(2,478,989)	(2,478,989)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Cost			19
20	Accumulated Amortization Organization & Pre-Operating Cost			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify)	78,745	78,745	22
23	Other(specify) Investments	163,048	163,048	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,236,219	$ 1,236,219	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,638,481	$ 2,638,481	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 630,245	$ 630,245	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposit			28
29	Short-Term Notes Payable	435,414	435,414	29
30	Accrued Salaries Payable	215,566	215,566	30
31	Accrued Taxes Payable (excluding real estate taxes			31
32	Accrued Real Estate Taxes(Sch.IX-B			32
33	Accrued Interest Payable			33
34	Deferred Compensation	218,562	218,562	34
35	Federal and State Income Taxe			35
	Other Current Liabilities(specify):			
36	Due to Third-Party Payor	100,000	100,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,599,787	$ 1,599,787	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	131,885	131,885	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 131,885	$ 131,885	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,731,672	$ 1,731,672	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 906,809	$ 906,809	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,638,481	$ 2,638,481	48

***(See instructions.)**

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 983,011	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 983,011	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	571,904	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Hospital Operations**	(760,122)	15
16	Other (describe) **Trust and investment return**	112,016	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (76,202)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 906,809	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,094,960	1
2	Discounts and Allowances for all Levels	(72,795)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,022,165	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,022,165	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services		31
32	Health Care	437,559	32
33	General Administration	9,500	33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers	3,202	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 450,261	40
41	**Income before Income Taxes (line 30 minus line 40)****	571,904	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 571,904	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,869	2,080	$ 36,940	$ 17.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	9,632	10,347	120,080	11.61	4
5	Nurse Aides & Orderlies	26,780	28,806	237,937	8.26	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,804	2,090	13,587	6.50	9
10	Activity Assistants					10
11	Social Service Workers	1,951	2,103	17,925	8.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beautician	491	493	3,004	6.09	33
34	TOTAL (lines 1 - 33)	42,527	45,919	$ 429,473 *	$ 9.35	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee benefits are allocated based on gross	
salaries through the Medicare cost report - no	
separate breakout of benefits available	98,323
TOTAL (agree to Schedule V, line 22, col.8)	$ 98,323

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed ____)	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	221
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 221

**See instructions.

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Thomas H Boyd Memorial Hsp # 8027823 Report Period Beginning: 9/1/00 Ending: 8/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **NO**

(2) Are there any dues to nursing home associations included on the cost repor **NO**
If YES, give association name and amount

(3) Did the nursing home make political contributions or payments to a politic
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report

(4) Does the bed capacity of the building differ from the number of beds licensed at tl
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchase **YES**
What was the average life used for new equipment added during this period **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expen
and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedur
consistent with prior reports? **YES** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangemen **NO**
If YES, give effective date of lease

(9) Are you presently operating under a sublease agreement YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f
Schedule VII)? YES NO **X** If YES, please indicate name of the facility
IDPH license number of this related party and the date the present owners took ove

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme
of Public Aid during this cost report period. **21,870**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule
for an individual employee **NO** If YES, attach an explanation of the allocation

(13) Have costs for all supplies and services which are of the type that can be billed
the Department of Public Aid, in addition to the daily rate, been properly classifi
in the Ancillary Section of Schedule V **YES**

(14) Is a portion of the building used for any function other than long term care services f
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, atta
a schedule which explains how all related costs were allocated to these function

(15) Indicate the cost of employee meals that has been reclassified to employee benef
on Schedule V. $ **20,868** Has any meal income been offset agains
related costs? **YES** Indicate the amount. $ **45,445**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **NO**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation f
residents? **NO** If YES, please indicate the amount of income earned from such
program during this reporting period.
c. What percent of all travel expense relates to transportation of nurses and patient **NONE**
d. Have vehicle usage logs been maintained **N/A - NO VEHICLES**
e. Are all vehicles stored at the nursing home during the night and all oth
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjuste
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm **YES**
Firm Name: **BKD, LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this co
been attached? **YES** If no, please explain

(18) Have all costs which do not relate to the provision of long term care been adjusted o
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic
performed been attached to this cost report **N/A**
Attach invoices and a summary of services for all architect and appraisal fe

Reisch Memorial Nursing Home
Schedule of Other Adjustments
8/31/2001

G/L Acct. #	Description	Amount	
60624.045	Nursing Home Pharmacy	58,761	
60652.035	Nursing Home Central Supply	14,607	
		73,368	Sch. VI, Page 5, Line 35